I am Jim Firman, President and CEO of The National Council on the Aging (NCOA) – the nation's first organization formed to represent America's seniors and those who serve them. Founded in 1950, NCOA is a national network of organizations and individuals dedicated to improving the health and independence of older persons; increasing their continuing contributions to communities, society and future generations; and building caring communities. Our 3,800 members include senior centers, adult day service centers, area agencies on aging, faith congregations, senior housing facilities, employment services, and other consumer organizations. NCOA also includes a network of more than 14,000 organizations and leaders from service organizations, academia, business and labor who support our mission and work.

I appreciate having the opportunity to participate in today's hearing: *The New Medicare Drug Discount Card: An Advance Prognosis*. The availability of new prescription drug and other benefits under Medicare creates an unprecedented opportunity and a unique set of challenges. As a transition to Medicare Part D prescription drug coverage in 2006, the discount card program and accompanying transitional assistance will be available this June. Medicare-approved cards are expected to offer savings of about 10 to 15 percent on total drug costs, with savings of up to 25 percent or more on individual prescriptions. The benefit for many low-income beneficiaries, however, is likely to be much more significant.

Enactment of the new Medicare law is the single-most important opportunity to help low-income Medicare beneficiaries to have emerged in the past 35 years. Medicare approved discount cards will include a $600 transitional assistance (TA) credit for those with annual income below 135 percent of poverty (this year, $12,569 for singles; $16,862 for couples), regardless of assets. The credit is not available to those with drug coverage from Medicaid, TRICARE for Life or an employer group plan.

Savings for Low-Income Beneficiaries: Opportunities and Challenges

To achieve the law's full potential, it is imperative to maximize TA enrollment, and savings from other programs, for low-income beneficiaries. We know from experience and research that this population is more likely to have chronic and/or cognitive illnesses and tends to be very difficult to reach, with enrollment goals hard to achieve.

In recent years, government agencies at all levels, voluntary organizations and foundations have been involved in efforts to identify and enroll low-income beneficiaries who are eligible for but not receiving needed benefits from government and private programs. To date, success on this front has been at best inconsistent and uneven.

For example, take-up rates for the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs – for beneficiaries with incomes below 120 percent of poverty – are estimated at only 43 percent. Participation in the Qualified Individual (QI) program – for beneficiaries with incomes between 120 and 135 percent of poverty – is significantly lower. Take-up rates for Food Stamps and the SSI elderly program are estimated to be as low as 54 and 50 percent, respectively. The bottom line is that millions of vulnerable, low-income seniors and younger persons with disabilities are not receiving the assistance they are eligible for. We must do better.

In just a few months, in order to maximize available savings, most low-income beneficiaries will need to enroll in a Medicare-approved discount card AND enroll in additional public and private benefits programs in order to afford the prescription drugs they need to maintain their health and improve the quality of their lives. Then, beginning in 2006, low-income beneficiaries will have a different and even more confusing set of options regarding enrollment decisions in Part D.

Medicare beneficiaries are already very confused about the new law. Millions of beneficiaries want and expect immediate help with their prescription drug expenses. Some believe that broad Medicare prescription drug coverage will be available this year; they will be disappointed. Virtually all will want to know what kinds of price discounts are available to them and how to apply. Further exacerbating the confusion, states will continue to make significant changes to their prescription drug programs. Last year alone, 49 states had more than 270 bills filed to create, expand or substantially change state pharmaceutical programs and policies.

Last year, a Kaiser Commission report on access to benefits for low-income seniors recommended that policy makers must "improve marketing efforts for Medicaid and state pharmacy assistance programs so that more seniors learn about the programs. A key to these marketing efforts should be to inform seniors that they might, in fact, be eligible." More recently, a Kaiser Family Foundation survey conducted just one month ago found that only 15 percent of senior respondents (7 percent of the public overall) said that they understood the new prescription drug law very well and almost 7 in 10 did not even know that it passed and was signed into law. The findings led Kaiser's President and CEO Drew Altman to conclude: "The complex nature of the law, with all its nooks and crannies and winners and losers, makes the public education challenge much harder. It will take customized one-on-one assistance to really give beneficiaries meaningful help."

There are both short-term and long-term imperatives and opportunities to ensure that as many low-income seniors as possible get the new benefits. In 2004 and 2005, there will be 7.4 million low-income beneficiaries who will be eligible to receive the $600 credit, but CMS estimates that 2.7 million of those eligible will fail to enroll and will forfeit the benefit. An estimated 14.1 million seniors will be eligible for the full low-income benefits which begin in

January 2006. These benefits will pay for between 85 percent and almost 100 percent of prescription drug costs. But the CBO estimates that 8.7 million low-income beneficiaries will receive benefits by 2013. This is only 70 percent of eligible beneficiaries after seven years of program implementation.

We are pleased that the key health leaders in Congress share our concerns about the importance of ensuring that vulnerable low-income beneficiaries receive the new Medicare benefits they are eligible for. Strong, clear report language was included in the Medicare bill on improving outreach to low-income beneficiaries. The language states:

> "[T]he Conferees expect that… HHS will place a priority on, and make a best and concerted effort to, ensuring that the lower income seniors are aware of the additional benefits available to them and how to enroll. Therefore, the public information campaign should include a program of outreach, information, appropriate mailings, and enrollment assistance with and through appropriate state and federal agencies, including State health insurance counseling and assistance programs, in coordination with other federal programs of assistance to low-income individuals, to maximize enrollment of eligible individuals. In addition, special outreach efforts shall be made for disadvantaged and hard-to-reach populations, including targeted efforts in historically underserved populations, and working with low-income assistance sites and a broad array of public, voluntary, and private community organizations serving Medicare beneficiaries. Materials and information shall be made available in languages other than English, where appropriate." [Joint Explanation Statement of the Committee of Conference, page 432]

NCOA and others supported the new Medicare legislation primarily because of the benefits it would provide to Medicare beneficiaries with low-incomes and/or catastrophic drug costs. We are committed to ensuring that as many low-income Medicare beneficiaries as possible know about and take advantage of the "safety net" provisions of the new law. We view this as an extraordinary and time-sensitive opportunity to organize and mobilize a broad public-private partnership to significantly increase projected participation rates by low-income beneficiaries.

The importance of accelerating progress on this front is underscored by the opportunities and challenges inherent in enrolling low-income beneficiaries in the TA benefit. In response, CMS and SSA are organizing an outreach and education campaign primarily targeted to all beneficiaries. Defining features of the emerging CMS awareness campaign include beneficiary publications and mailings; a national advertising campaign; enhanced support through 1-800-MEDICARE and www.medicare.gov; provider education and outreach; training and support of state health insurance programs (SHIPs), State Units and Area Agencies on Aging, and other sources of information and counseling; as well as active partnerships with other public agencies and the voluntary sector.

While these awareness efforts will reach millions of low-income beneficiaries, years of experience tell us that there also needs to be complementary, coordinated initiatives that go much deeper into the community in order to educate consumers, help them make informed choices and facilitate their actual enrollment in the new Medicare benefits. In the past, there have been few opportunities to evaluate or identify and systematically implement effective outreach and enrollment methods to reach this difficult to reach audience.

Access to Benefits Coalition

In response to the significant challenges and opportunities created by the new law, NCOA is forming the Access to Benefits Coalition (ABC) – a public-private partnership dedicated to ensuring that low-income beneficiaries know about and can make optimal use of new Medicare prescription drug benefits and all other available resources for saving money on prescription drugs. ABC members share an interest in helping Medicare beneficiaries (including both those aged 65 and over as well as younger persons with disabilities who qualify) find the

public and private prescription savings programs they need to maintain their health and improve the quality of their lives.

The goal of ABC is to quickly and measurably educate low-income Medicare beneficiaries, help them make informed choices about prescription savings programs, and facilitate their actual enrollment in new Medicare benefits through:

- Developing and using the best-available knowledge from the public and private sectors about best practices and cost-effective strategies for reaching and enrolling low-income Medicare beneficiaries.
- Activating and supporting nationwide community education and outreach, focused on reducing confusion and providing beneficiary support in decision-making and enrollment.
- Developing and implementing a public information and outreach campaign that complements and extends CMS efforts at the local level.
- Disseminating sophisticated decision-support tools to help consumers make optimal choices; and
- Mobilizing widespread support and participation in national, state and local Access to Benefits Coalitions (four are already in formation).

The ABC is committed to achieving aggressive enrollment goals (numbers are tentative, based on preliminary analysis) including: (1) By the end of 2005, at least 5.5 million low-income beneficiaries will have received $600 in transitional assistance under a Medicare-endorsed discount card, and also will have had an opportunity to enroll in other public and private Rx programs available to help them save money; (2) By the end of 2008, at least 8 million low-income beneficiaries will have enrolled in Medicare low-income savings programs; and (3) By

2012, at least 12 million low-income beneficiaries will have enrolled in Medicare low-income savings programs.

Among the many unique strengths and capabilities that the Access to Benefits Coalition brings to bear on achieving these objectives are:

- Common purpose and commitment;
- Broad representation;
- Exceptional credibility;
- Unprecedented reach;
- National influence;
- Community leadership;
- Depth of knowledge and experience with target audiences;
- Proven decision-support tools and other enrollment-support capabilities; and
- Ability to integrate otherwise disparate and competing efforts.

Key organizing members of the Coalition include: NCOA, AARP, Alzheimer's Association, American Association of People with Disabilities, Catholic Health Association, Center for Medicare Advocacy, Easter Seals, National Alliance for Hispanic Health, National Assembly of Health and Human Service Organizations, National Association for Hispanic Elderly, National Association of Area Agencies on Aging, National Association of Nutrition and Aging Services Programs, National Association of State Units on Aging, and National Medical Association. Other current members of the Coalition include the American Diabetes Association, American Health Care Association, National Adult Day Services Association, National Association of Community Health Centers, National Rural Health Association, and Volunteers of America. The national Access to Benefits Coalition is expected to include more than 100 core organizations.

The Coalition has formed three Working Groups: Outreach and Mobilization, Research and Policy, and Media and Public Relations. State and local ABCs will mirror the national Coalition, and provide broad and deep grassroots support and mobilization. Every member organization shares a commitment to helping low-income Medicare beneficiaries connect to new Medicare Rx and other Rx benefits, public and private. Coalition partners will include:

- CMS, AoA, SSA and other Federal agencies;
- State health insurance counseling programs, state and area agencies on aging and other aging/disability services;
- State and local governments;
- Health care organizations and systems;
- Physician, pharmacist and other health provider groups;
- Business community, including pharmaceutical and pharmacy companies, PBMs, employers, media; and
- Private foundations.

Decision Support Tools

The use of enhanced decision support tools will also be a key strategy of the Access to Benefits Coalition. Low-income beneficiaries are already confused about new benefits and will face increasingly complex choices. New Medicare transitional benefits are only one of several important components of an Rx safety net - hundreds of other public and private Rx programs are also available. Most low-income beneficiaries will need to take advantage of several of these programs to be able to afford their medicines. People with incomes greater than 135% of poverty will be especially in need of help.

In June 2001, NCOA launched BenefitsCheckUp, a new free, Web-based public service to allow seniors, their families, and the community organizations that serve them to quickly and easily determine what benefits are available and how to apply for them. BenefitsCheckUp offers an alternative to standing in long lines or spending weeks or even months trying to get information about approximately 1,200 federal, state, local and private programs. By taking a few minutes to fill-out a confidential on-line survey, seniors and their families who visit www.BenefitsCheckUp.org can access a detailed report on the benefits that may be available. For some benefits, consumers can download the actual application form to further facilitate enrollment. Over one million seniors and their families have used the service so far.

In January 2003, the Web site was expanded through BenefitsCheckUpRx to include approximately 260 public and private programs to assist seniors in determining what help they can get to pay for prescription drugs. Users can access a questionnaire specifically tailored to promote access to these Rx benefits. The service is also available in Spanish.

NCOA is now developing an enhanced version of BenefitsCheckUpRx to facilitate decision-making and enrollment in a full range of savings programs. The new decision-support tool will help beneficiaries to determine the **individualized combination** of programs that will save the most money – not only new Medicare benefits, but state pharmaceutical assistance programs, discount card programs that are not Medicare endorsed, and over 130 private drug company patient assistance programs. With the cooperation of card sponsors, we also hope to ease the burden of completing enrollment forms by including printable e-forms for Medicare-endorsed cards and the other important savings programs.

We know that many of the seniors who could benefit the most from using BenifitsCheckUpRx do not have access to the Internet. Therefore, thousands of coalition

members (staff and volunteers) will be trained and supported to serve as intermediaries with low-income beneficiaries to use this new tool.

Transitional Assistance Benefit Will Deliver Additional Savings

There is some very good news to report about the Transitional Assistance benefit: most low-income beneficiaries who enroll in the TA program will save a lot more than $600 in 2004 and 2005. This is because of the commendable actions by several pharmaceutical manufacturers to offer savings programs for low-income seniors that "wrap around" the Medicare-approved cards. For example, Merck recently announced that once a Medicare beneficiary uses up their $600 debit on a Medicare-approved card that person can purchase their Merck medications for the rest of the year for only a dispensing fee. Eli Lilly has announced that people who qualify for and enroll in the TA program can purchase any Lilly drug for $12 per month, even when they still have a balance on their card. TogetherRx, which covers more than 170 medications from seven leading manufacturers, will continue to offer savings of 20% to 40% to people who qualify. Pfizer has indicated that it intends to continue to make its ShareCard available to Medicare beneficiaries, enabling them to purchase Pfizer medications for $15 per month.

The bottom line is that low-income beneficiaries who take multiple medications and who have incomes below 135% of poverty could save from 40% to 90% on their medications in 2004 and 2005. Exactly how much an individual will save depends on the specific medications they take, what they are currently paying for them and what the dispensing fees will be at the pharmacy they use. Below are two examples for a Medicare beneficiary who lives in Idaho or Louisiana:

2004-05 savings to low-income beneficiaries may be much greater than $600.

Example #1: An 82-year old Idaho man with income of $10,000 and assets of $20,000

Medication, monthly cost, manufacturer	Current annual cost to consumer	Manufacturer's wrap-around assistance to Medicare TA program	Annual out-of-pocket cost with Medicare TA + manufacturer's wrap around assistance
Pulmicort Turbuhaler – 200 mg $130 per month, made by Astra Zenica	**$1,560**	After TA is used up, consumers can buy medications for $15 per Rx per month + dispensing fee (through the TogetherRx program).	**$165 drug costs** **$55 dispensing fees**
Zocor – 10 mg $70 per month, made by Merck	**$840**	After TA is used up, consumers can get the medications for only the dispensing fee.	**$0 drug costs** **$55 dispensing fees**
Zyprexa – 10 mg $260 per month, made by Lilly	**$3,120**	Consumers can purchase medications for $12 per month + dispensing fees.	**$132 drug costs** **$55 dispensing fees**
Total Cost to Consumer	**$5,520**		**$462**

Estimated Annual Savings = $5,058

Example #2: A 68-year old Louisiana woman with income of $11,000 and assets of $30,000

Medication, monthly cost, manufacturer	Current annual cost to consumer	Manufacturer's wrap-around assistance to Medicare TA program	Annual out-of-pocket cost with Medicare TA + manufacturer's wrap around assistance
Aricept – 10mg $130 per month, made by Pfizer	**$1,560**	Consumers can buy medications for $15 per Rx per month + dispensing fee.	**$90 drug costs**
Serezent – 50 mcg $85 per month, made by GSK	**$1,020**	After TA is used up, consumers can get the medications for an estimated 30% discount + dispensing fee (through the TogetherRx program).	**$357 drug costs** **$30 dispensing fees**
Total Cost to Consumer	**$2,580**		**$477**

Estimated Annual Savings = $2,103

Policy Issues

There are also a number of ways in which implementation of the discount card program, and enrollment in the TA benefit, can be improved. For example, NCOA is hopeful that current Medicare Savings Program (MSP) recipients (QMBs, SLMBs, and QI-1s) can be automatically enrolled in the $600 TA program. Current MSP beneficiaries could be informed directly of the Medicare-endorsed discount cards serving their area and asked to select one by simply returning a postcard. If a selection is not made within a period of time, they could be automatically assigned a card on a rotating basis, so no card would be favored. By automatically enrolling the MSP population, about 700,000 individuals could be assured enrollment. In addition, a process should be designed for identifying TA enrollees who are not enrolled in an MSP program, so that prompt follow-up can occur to determine if they are eligible for MSP benefits.

We also believe it is important to simplify the discount card application process. CMS should develop or authorize use of a universal application form that would permit applicants to check a box for a chosen card sponsor. It will be difficult for front-line workers and volunteers doing one-on-one application counseling and assistance if they must have and use potentially more than 20 or 30 different forms in some parts of the country. Making available a single form for all card sponsors would greatly simplify enrollment, reduce confusion, and improve participation in the discount card and TA programs.

Conclusion

Enactment of the new Medicare law is the single-most important opportunity to help low-income Medicare beneficiaries to have emerged in the past 35 years. NCOA is firmly committed to working with a broad range of partners to take full advantage of this opportunity to provide much-needed assistance to this vulnerable, hard-to-reach population.

Getting low-income beneficiaries enrolled in the savings programs is essential. Historically, efforts to identify and enroll low-income consumers eligible for needed benefits from government and private programs have been at best inconsistent and uneven. While proposed CMS and SSA awareness efforts will reach millions of low-income beneficiaries, there also needs to be complementary, coordinated initiatives that go much deeper into the community in order to educate consumers, help them make informed choices and facilitate their actual enrollment in the new Medicare benefits.

In response to the significant challenges and opportunities created by the new law, NCOA is forming the Access to Benefits Coalition – a public-private partnership dedicated to ensuring that low-income beneficiaries know about and can make optimal use of new Medicare prescription drug benefits and all other available resources for saving money on prescription drugs. NCOA is also developing an enhanced version of BenefitsCheckUpRx to facilitate decision-making and enrollment in a full range of savings programs. The new decision-support tool will help beneficiaries to determine the individualized combination of programs that will save them the most money.

It is also important to understand that most low-income seniors who enroll in the Transitional Assistance credit program will save a lot more than $600 in 2004 and 2005. This is because of the commendable actions by several pharmaceutical manufacturers to offer savings programs for low-income beneficiaries that "wrap around" the Medicare-approved cards.

NCOA is also interested in opportunities to automatically enroll Medicare Savings Program recipients in the TA benefit, and to create a universal discount card enrollment form.

By working together on these initiatives, we can significantly improve the quality of the lives of millions of vulnerable Medicare beneficiaries in need this year.